The Career of the Mentally Ill: An Integration of Psychiatric, Labeling/Social Construction, and Lay Perspectives
Author(s): Walter R. Gove
Source: *Journal of Health and Social Behavior*, Vol. 45, No. 4 (Dec., 2004), pp. 357-375
Published by: American Sociological Association
Stable URL: http://www.jstor.org/stable/3653811
Accessed: 23-11-2015 05:37 UTC

Your use of the JSTOR archive indicates your acceptance of the Terms & Conditions of Use, available at http://www.jstor.org/page/info/about/policies/terms.jsp

JSTOR is a not-for-profit service that helps scholars, researchers, and students discover, use, and build upon a wide range of content in a trusted digital archive. We use information technology and tools to increase productivity and facilitate new forms of scholarship. For more information about JSTOR, please contact support@jstor.org.

Sage Publications, Inc. and American Sociological Association are collaborating with JSTOR to digitize, preserve and extend access to *Journal of Health and Social Behavior*.

http://www.jstor.org

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

The Career of the Mentally Ill: An Integration of Psychiatric, Labeling/Social Construction, and Lay Perspectives*

WALTER R. GOVE
Vanderbilt University

Journal of Health and Social Behavior 2004, Vol 45 (December): 357–375

This paper provides a new way of conceptualizing the career of the mentally ill. Most persons who experience an episode of a serious mental disturbance lead a normal life, while a few persons lead lifetimes that revolve around their mental disorders. The processes leading to either result can only be understood by integrating the traditional labeling and psychiatric perspectives with lay understandings of the concepts of "mental illness" and "nervous breakdowns." A selection of key concepts from these perspectives leads to a better understanding of the different paths persons take as they move through the pre-patient, in-patient, and post-patient phases of the "career of the mentally ill." This perspective makes understandable a number of counterintuitive relationships. For example, it explains why most hospitalized mental patients (1) have a negative stereotype of the "mentally ill," (2) do not perceive themselves as "mentally ill, yet (3) perceive themselves as benefiting from treatment, and (4) do not progress into a career of secondary deviance.

Most persons whom mental health professionals would perceive as needing psychiatric treatment and whom labeling theorists see as having been labeled "mentally ill" are perceived by the lay public as *probably* having a "nervous breakdown," a disorder which they view as transitory and less serious than "mental illness." Labeling/social construction theorists have ignored the existence of "nervous breakdowns" despite it being a widely held lay social construct; mental health professionals, on the other hand, focus on what they consider to be "objective disorders" and ignore issues related to lay conceptions of "mental illness" and "nervous breakdowns."

In discussing the "career of the mentally ill," I largely follow the framework used by Karp (1996) and Aneshensel (1999). According to this framework many persons spend a lifetime being normal, even though they may occasionally experience periods when they are very distressed and /or act in problematic ways. This occurs because it *is* normal for persons to experience distress and, at times, to act in problematic ways. A career of mental illness starts when the prospective patient and/or those close to the prospective patient strongly sense that something is wrong, and that sense shapes one's actions and the actions of those around the person. In some cases these actions lead to psychiatric treatment and in a few cases to mental hospitalization. In most cases treatment, time, and/or changes in one's life situation lead to an abatement of symptoms, sometimes partial, sometimes complete. To understand the processes that lead to this variety of outcomes, we need to draw on and integrate information from the various conceptions of mental illness.

The implications of this combined perspective require a focus on the "career of mental illness" that examines the pre-patient, in-patient, and post-patient phases of that career. It also requires a consideration of the following issues: the evolving changes in where particular types of mental disorders are treated, the places where psychiatric hospitalizations occur, how the characteristics of patients in public mental hospitals differ from those treated in other settings, and attention to the distinction between incidence and prevalence.

* I have benefited greatly from the comments by Michael Hughes and Margaret Smith who have provided invaluable assistance in the preparation of this paper.

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

LAY CONCEPTIONS OF MENTAL DISORDER

A *nervous breakdown* is seen by the lay public as a transitory disorder that almost anyone might experience if they were subjected to an inordinate level of stress. Because persons undergoing a nervous breakdown are physically and emotionally overwhelmed by the demands they confront, they need a relatively stress-free "time-out" period during which they can reappraise their lives and work toward a return to normal levels of functioning. In contrast, the lay public sees *mental illness* as a more serious and chronic disorder and views the trajectory of a person who is mentally ill as extremely problematic.

"Mental Illness": The Archetypal Case

An extensive literature indicates that the lay public tends to believe that persons who are "mentally ill" are dirty, bizarre, unpredictable, and dangerous (Rabkin 1980; Link et al. 1992). This stereotype is widely held for several reasons. First, there is some truth in it (Murphy 1976, Link et al. 1992; and Horwitz 2002; Torrey 1988). Second, dangerous behavior is a prerequisite for civil commitments to mental hospitals in many states (Gove et al. 1985), and persons with a psychotic disorder are found disproportionately in correctional facilities (Hodgins 1993). Third, the legal defense "not guilty because of insanity" receives wide publicity (Rabin 1980:21). Finally, the news and entertainment media frequently depict the mentally ill as bizarre and dangerous (Scheff 1984; Monahan 1992; Wahl 1995; Rabkin, 1980). In short, this stereotype of "mental illness" is linked to both an empirical reality and to socially constructed definitions prominent in the mass media. Following Strauss et al. (1979) I refer to these persons as the "archetypal mentally ill."

Nervous Breakdowns ("Nerves")

In his cross-cultural study of public attitudes toward mental patients, Askanasy (1974) found that mental patients were typically viewed as having a "nervous breakdown," not as being "mentally ill." Askanasy's community of respondents characterized nervous breakdowns as resulting from environmental pressures. People overwhelmed by such stress were seen often as requiring brief hospitalization; however, their problems were also viewed as temporary and curable. In contrast, Askanasy (1974) found that "mental illness" was seen as persistent, incurable, affecting all spheres of functioning, requiring long periods of hospitalization, and not closely tied to the experience of stress.

The concept of nervous breakdowns has evolved since the nineteenth century when persons experiencing high levels of stress were viewed as having neurasthenia, which was believed to be a physical disorder. Over time, as neurasthenia became a psychiatric diagnosis, individuals started diagnosing themselves as having a nervous breakdown, which was seen as a normal reaction to high levels of stress (e.g., see Kleinman 1986). In the landmark studies *Americans View their Mental Health* by Gurin, Veroff and Feld (1960) and *Mental Health in America* by Veroff, Kulka and Douvan (1981) respondents who felt they had experienced "an impending nervous breakdown" were in the poorest mental health. These respondents were also the persons most likely to seek help for their problems, and a few of these respondents had a psychiatric hospitalization.

The lay population is becoming increasingly familiar with the diagnostic categories in DSM III-IV, and there is a developing awareness that the concept of a nervous breakdown is not a "scientific diagnosis." At the same time, in both the professional and popular literatures, stress is being treated as causing a wide array of mental and physical disorders. The way the stress overload model used in these literatures is very similar to the way in which stress has been presumed to lead to a nervous breakdown. At present it appears that some persons are keeping the stress overload model of a nervous breakdown but, instead of using the term "nervous breakdown" focus instead on a person's inability to handle the high level of stress experienced. If persons do not use the term "nervous breakdown" because it is not "scientific," it does not follow that they have rejected the underlying processual model that has been associated with a nervous breakdown. In this paper, for reasons of clarity and simplicity, I focus on the lay concept of a nervous breakdown.

Concepts similar to a nervous breakdown

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

are common across many cultures. For example, in our society, persons from Appalachia use the term "nerves" instead of nervous breakdown. Low (1985) discusses the similarity of the concept of nerves across an array of cultures, and the edited book by Davis and Low (1989) expands on this position. Baer et al. (2003:317), drawing on the work by Guarnaccia (1993), indicates "that in Latino populations *Nervios* is consistently described as a culturally approved reaction to overwhelming stressful experiences, especially concerning grief, threat and family conflict." Kleinman (1986) presents an excellent discussion of how in China the diagnosis of neurasthenia, which is viewed as a biological reaction to an overload of stress, is preferred over a psychiatric diagnosis (see also Kleinman and Good (1985).

Most acutely ill mental patients do not see themselves as "mentally ill," nor do their relatives. This is true even though they are experiencing considerable distress, are clearly symptomatic, are in treatment, and perceive themselves as needing treatment (Yarrow et al. 1955; Clausen 1981; Whitt and Meile 1985; Weinstein 1994). These reactions occur for at least two reasons. First, most hospitalized mental patients correctly perceive that their "disorder" differs substantially from the stereotype of the archetypal mentally ill (Strauss et al. 1979; also see Townsend and Rackfelt 1985 and Rabkin 1980). Second, the symptoms and experiences of these persons correspond to the lay concept of a "nervous breakdown," a disorder presumed to have an understandable etiology and trajectory and perceived as being less serious than "mental illness."

In 1996 the GSS included a module on mental health. Half of the respondents were asked, "Everybody hears a good deal about physical illness and disease, but now, what about the ones we call mental or nervous illness? When you hear that someone is mentally ill what does that mean to you? The other half were asked, "As far as you know, what is a nervous breakdown"? The interviewer reported only the first three responses given to these questions. These responses were then collapsed into 97 categories. Using a theoretically guided scheme, my assistant, Ranae Evenson, and I combined these 97 categories into 14 symptom categories that accounted for more than 97 percent of the responses. The symptom categories and the percent of respondents indicating that the symptoms were characteristic of each lay disorder type (nervous breakdown and mental illness) are presented in Table 1.

Respondents to the "nervous breakdown" question were much more likely to describe symptoms fitting into the categories of Distress, Unable to Function/Overwhelmed/No Self-control, Psychosomatic Symptoms, and Denial than were respondents to the "mental illness" question (62.3 to 21.1 percent). In contrast, respondents to the "mental illness"

TABLE 1. All mentions of the symptoms of mental illness and nervous breakdowns: General Social Survey, 1996.

Types of Symptoms	"Nervous Breakdown Symptoms"	"Mental Illness Symptoms"
Distressed	21.8% (330)	6.9% (98)
Unable to Function/Overwhelmed/No Self-control	29.0% (439)	10.6% (151)
Psychosomatic Symptoms	5.9% (89)	1.8% (25)
Denial	5.6% (85)	1.7% (24)
Subtotal	**62.3%**	**21.0%**
Psychotic	7.2% (109)	13.9% (197)
Bizarre Behavior	4.2% (64)	20.5% (291)
Violence	2.8% (43)	7.2% (102)
Disease of Brain/Illness	.7% (11)	3.6% (51)
Crazy, Bonkers, Nuts, Looney	1.7% (26)	3.7% (53)
Withdrawn & Dependent, Impaired	9.1% (138)	16.5% (234)
Erratic	9.0% (136)	10.7% (152)
Subtotal	**34.8%**	**76.1%**
Criminal Behavior/Chronic Lying	.2% (3)	.2% (3)
Alcohol/Drug Abuse	.4% (6)	.4% (5)
Other	2.2% (34)	2.4% (34)
Subtotal	**2.8%**	**3.0%**

Note: Due to rounding, the numbers in this Table do not sum to 100%.

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

question were much more likely to describe symptoms that fit under the category of Psychotic, Bizarre Behavior, Violence, Disease of the Brain/Illness, Crazy/Bonkers/Nuts/Loony, and Erratic than were respondents to the "nervous breakdown" question (71.6 to 34.7 percent). Both sets of respondents rarely indicated that Criminal Behavior/Chronic Lying symptoms (0.2 percent) or Alcohol/Drug Abuse symptoms (0.4 percent) were relevant to either "mental illness" or "nervous breakdowns."

These results clearly indicate that 1) mental illness is generally perceived as a more serious disorder than a nervous breakdown, and 2) most persons do not associate substance disorders and anti-social personality disorders with mental illness or having a nervous breakdown (see also Swindel et al. 2000; Martin, Pescosolido, and Tuch 2000; and Gove and Evanson 2003). Clearly, the public's notions of nervous breakdown and mental illness are distinct from psychiatric conceptions, and they do not include many of the disorders found in *DSM III-IV*. In addition, these findings are consistent with the idea that mental illness is not a psychiatric diagnosis, but is instead a lay construct.

Three other studies using this data set illuminate important elements of lay conceptions of mental illness and nervous breakdowns. First, while the tendency of the public to associate mental illness with potentially fearful symptoms (unpredictable behavior, violence, etc.) increased between 1956 and 1996, the vast majority of the public, nearly 90 percent, do not describe the mentally ill in this way (Phelan et al. 2000). Second, an analysis using vignettes of persons with different psychiatric disorders showed that respondents tend to prefer a greater social distance from persons with substance disorders than from persons with other disorders, including schizophrenia (Martin, Pescosolido and Tuch 2000). Third, between 1956 and 1996, the percent of persons who report having experienced an impending nervous breakdown increased from 18.9 to 26.4 percent (Swindel et al. 2000). This change cannot be accounted for by demographic factors and is most likely due to a decline in the stigma of admitting one is going to have a nervous breakdown and/or to an increase in psychological problems. Results also indicated that 3.3 percent of those who reported an impending nervous breakdown had experienced a psychiatric hospitalization.

Although the public does not perceive a "nervous breakdown" as being as serious as "mental illness," it is still viewed as a serious disorder. After all, *a nervous breakdown is associated with a high level of distress and an inability to meet one's obligations*. At the minimum one needs "time out," and one or more of a variety of different forms of treatment are typically perceived as necessary. In addition, people tend to view a "nervous breakdown" as falling somewhere between "normal behavior" and "mental illness," and this boundary is not sharply delineated (Askanasy 1974). Although the problems of most persons who have a "nervous breakdown" are perceived as transitory, there is the belief that for some individuals what was initially perceived as being a "nervous breakdown" may turn out to have been an early stage in the development of "mental illness" (also see Guarniccia et al. 1992:195 and Lopez and Guarniccia 2000).

Summary

The concepts of a "nervous breakdown" and of "mental illness" are widely used social constructs that are loosely tied to objective realities. Having a "nervous breakdown," although incapacitating, is viewed as transitory in nature and appears to be less stigmatizing than it was in the past. The vast majority of the population does *not* fear the "mentally ill," but they do see them as having a serious chronic disorder involving high levels of behavioral and mental impairment.

THE INSTITUTIONALIZATION OF PERSONS WITH MENTAL DISORDERS

While most persons who receive psychiatric treatment today have a disorder that conforms to the lay conception of a nervous breakdown, and most chronic mental patients fit the public image of the mentally ill, this has not always been the case. Fifty years ago, persons institutionalized for a mental disorder were typically committed to a public mental hospital, and these commitments included a combination of persons with severe and chronic disorders and persons with an acute transitory disorder (Hughes and Gove 1981). Since that time the

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

mental health treatment system has been transformed. Persons institutionalized for mental disorders may now be treated in a variety of settings, with a significant array of separate treatment centers for different types of mental disorders. The research implications of these changes are immense. We cannot accurately interpret the results of any particular study regarding the "career of the mentally ill" unless we are attentive to the location of the person within the mental health treatment system as well as the person's case attributes.

Changes in Institutionalization

Table 2 presents census data from 1960–2000 to show the rates of institutionalization of mental disorder in different types of institutions. Over time, the rate (per 100,000) of persons residing in mental hospitals has been sharply reduced. Correspondingly, there has been a major increase in the development of (1) homes for the mentally ill, (2) homes for persons abusing drugs and alcohol, and (3) hospitals and wards that focus only on these addictive disorders. In addition, the proportion of persons residing in nursing homes increased, and the rate of institutalization for mental retardation declined between 1960 and 1980 and then stabilized. These changes are all part of the de-institutionalization process (Cook and Wright 1995).

Changes in Psychiatric Treatment over Time

Table 3 (adapted from Manderscheid and Hender 2001:Tables 14.3 and 14.4) presents an overview of the key changes in psychiatric treatment that occurred between 1969 and 1998, and includes rates of inpatient treatment, percent share of inpatient admissions in different treatment settings, and rates of outpatient treatment. During this period, the rate of mental hospital admissions per 100,000 persons increased substantially, but the percent of admissions that occurred in public mental hospitals declined sharply, and there was a marked increase in the proportion that occurred in private hospitals and psychiatric wards of general hospitals. The remaining hospitalizations occurred in a wide variety of "other" settings, and over time there has been considerable variation in where these "other" hospitalizations occurred.

Table 3 also shows that the number of persons receiving outpatient care in a mental health facility now substantially exceeds the number of hospitalized mental patients (and these figures do not include private outpatient treatment). A small proportion of the persons

TABLE 2. Rate per 100,000 Population for Persons with Mental Disorders, United States Census: 1960, 1980, 2000

	1960	1980	2000
Mentally Hospitals, Wards, Residential treatment centers	351.3	112.7	28.1
Homes for the mentally ill	—	—	22.7
Hospitals or wards for drug/alcohol abuse	—	—	6.8
Homes for drug/alcohol abuse	—	—	33.5
Homes & Schools for the mentally retarded	97.4	66.0	67.5
Nursing Homes	261.9	629.6	694.6

— indicates that the category was not used by the census reports in a given year.

TABLE 3. Types of Admissions to Psychiatric Treatment

	1969	1979	1990	1998
All In-Patient Admissions (Rate Per 100,000)	644.2	704.2	833.7	860
Public Mental Hospital	37.9%	24.9%	13.6%	8.9%
Private Mental Hospital	7.2%	9.1%	20.0%	20.8%
Psych. Wards in General Hospitals	37.3%	35.8%	47.2%	49.1%
Other	7.6%	30.2%	19.2%	20.7%[a]
All Outpatient Admissions (Rate Per 100,000)	603.8	1,236.60	1,352.40	1,474.60

[a] In 1998, VA medical centers: 6.2% (includes neuropsychiatric hospitals, VA general hospital psychiatric services, VA outpatient clinics); residential treatment centers for children: 2.1%; all other organizations: 12.4% (includes freestanding psychiatric outpatient clinics, partial care organizations, multiservice mental health organizations). Among facilities in the "other" category, the rates of admission varied widely over time.

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

in outpatient care are receiving partial care, a relatively new form of treatment where persons reside in the community but spend a number of hours a day in a treatment setting. Patients in partial care settings typically have chronic disorders and the patient populations have a high level of stability.

Attributes of Patients and Types of Hospital

Table 4 shows that the patients in public mental hospitals differ in important ways from patients in private psychiatric hospitals and psychiatric wards in general hospitals. The majority of patients in public hospitals would appear to be indigent or close to indigent. Most such hospitalizations are paid for by the state. In contrast, admissions to private psychiatric hospitals and psychiatric wards in general hospitals are paid for almost entirely by a combination of client fees, Medicare, and Medicaid. According to 1986 data, the legal status of patients in public mental hospitals was 41.6 percent voluntary, 51.1 percent involuntary civil, and 7.3 percent involuntary criminal, whereas the vast majority of admissions to private mental hospitals and psychiatric wards in general hospitals was voluntary. Whether they have affective or schizophrenic disorders, persons in public mental hospitals or psychiatric wards in general hospitals have a longer median length of stay than those in private hospitals. In addition, national data from 1987 indicates that, unlike other hospitals, in public mental hospitals a discernible number of patients have stays lasting many years (Leginski, Manderscheid and Henderson 1987).

Hospitalization for Schizophrenia and Affective Disorders

Schizophrenia and affective disorders are representative of disorders that the lay public interprets as "mental illness" and "nervous breakdown," respectively. Table 5 presents data on admissions for the year 1997 and inpatient residency at a single point in time (May 1, 1997) for patients with schizophrenia and affective disorders in public mental hospitals, private psychiatric hospitals, and psychiatric wards in general hospitals (the three types of hospitals that admit the most patients). The number of patients residing in all hospital types at a single point in time was only 6.6 percent of the overall admission rate, indicating that only a very small proportion of admissions were in residence at a given time. There were 2.2 times as many admissions for affective disorders as there were for schizophrenia, but there were 1.8 times as many residents with schizophrenia at one point in time as there were residents with affective disorders.

Evidence in Table 5 (and Table 4) also indicates that the resident population of patients with schizophrenia in public mental hospitals was largely composed of chronic patients who were in the hospital for a prolonged period of time. Public mental hospitals accounted for 16.1 percent of the admissions for schizophrenia but 74.3 percent of all residential schizophrenic patients. As reported in Table 4, the median length of stay for schizophrenic patients was approximately 38 days, and some patients have a very prolonged stay (Leginski, Manderscheid and Henderson 1987). Finally, in public mental hospitals, the ratio of residents to yearly admissions (.626) is much

TABLE 4. Attributes of Patients Admitted to Different Types of Hospitals

	Public Mental Hospitals	Private Mental Hospitals	Psychiatric Wards in General Hospitals
Financial Support (1992)			
% supported by State Mental Health Funds	72.5%	1.4%	3.8%
Legal Status (1986)			
Voluntary	41.6%	87.4%	84.2%
Involuntary, civil	51.1%	12.5%	15.1%
Involuntary, criminal	7.3%	0.1%	0.7%
Median Length of Stay—Days (1986)			
Affective Disorders	33	25	13
Schizophrenia	38	20	13

Source: 1986 data from 1986 Client/Patient Sample Survey of Inpatient, Outpatient, and Partial Care Programs. Survey and Reports Branch, Division of Biometery and Applied Sciences, National Institute of Mental Health; 1992 data from Manderscheid and Sonnenheim (1996:129–30).

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

TABLE 5. Hospitalization in Public Mental Hospitals, Private Mental Hospitals, and Psychiatric Ward in General Hospitals

	All Hospitals	Public Mental Hospitals	Private Mental Hospitals	Psychiatric Wards in General
Part A. Schizoprenia				
Admissions				
Total Admissions:	341,575	54,919	63,229	223,603
% of All Admissions for Schizophrenia		16.1	18.5	66.5
Resident Patients				
Total Residents	46,229	34,357	3,289	8,583
% of All Residents for Schizophrenia		74.3	7.1	18.6
Part B. Affective Disorders				
Admissions				
Total Admissions:	736,740	44,883	237,094	454,763
% of All Admissions for Affective Disorders		6.1	34.2	61.7
Resident Patients				
Total Residents	25,482	6,930	7,169	11,383
% of All Residents for Affective Disorders		27.2	28.1	44.6

Center for Mental Health Service, Substance Abuse and Mental Health Services Administration; Synectics for Management Decisions, Inc. 199

greater in public mental hospitals than the ratio based on the combined rates for private mental hospitals and psychiatric wards in general hospitals (.041).

Private psychiatric hospitals and psychiatric wards of general hospitals admit 83.9 percent of the patients with schizophrenia, but these patients tend to have a brief hospitalization, and very few of them are hospital residents at a particular point in time. It appears that a large proportion of these patients are having an acute transitory episode of the symptoms associated with schizophrenia that only requires a brief hospitalization. This is an unexpected finding given that schizophrenia is typically understood as a chronic disorder (Keith, Regier and Rae 1991:50). It is, however, consistent with the emerging consensus that schizophrenia is a mixture of closely interrelated disorders that differ substantially in the amount of dysfunction that is manifest (Helmuth 2003). Clearly more research is needed to understand what is going on with schizophrenic patients admitted to these types of hospitals.

Public mental hospitals account for only 6.1 percent of the admissions for affective disorders, while they account for 27.2 percent of the patients with an affective disorder who are residents. Given the general attributes of patients in public mental hospitals, that they admit only a small number of patients with an affective disorder, and their high residency rate, it seems very likely that these patients tend to have a more severe disorder than most patients hospitalized for an affective disorder.

Summary and Implications of Data on Psychiatric Treatment

Types of mental health treatment facilities and population groupings of persons with mental disorders have changed significantly over the past 40 years. These changes have direct implications on the studies of the careers of the mentally ill.

At the present time, the vast majority of the patients with schizophrenia and the affective disorders are admitted to psychiatric wards of general hospitals and private mental hospitals. Although information on these patients is limited, it appears that most of these patients have an acute transitory disorder. *These are the types of disorders that largely correspond to the public's conception of a nervous breakdown.* In contrast, patients admitted to public hospitals appear to have much more serious and chronic disorders and some of these patients have a prolonged hospitalization. Thus, although the proportion of patients admitted to public mental hospitals is fairly small, at any point in time they make up a high proportion of all persons residing in mental hospitals.

Most studies of hospitalized mental patients draw their sample from public mental hospitals and, more recently, from settings in the com-

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

munity that are designed to serve persons with serious and chronic disorders. However, as the classic study by Hollingshead and Redlich (1958) showed, if one focuses on incidence (new patients *admitted* for hospitalization over a specified period of time), the sampled patients will have less severe disorders than if one focuses on prevalence (patients in treatment at a given moment). Sociological studies of mental illness have tended to draw their samples from persons who have a disorder at the time of the study (prevalence), and as a consequence, they substantially under-sample persons with acute transitory disorders. Hollingshead and Redlich (1958) also show the importance of distinguishing between first admissions and re-admissions.

Using hypothetical data, it is easy to show how a failure to appreciate the distinction between incidence and prevalence can affect the data collected by those studying hospitalized mental patients. Suppose 10 chronically ill mental patients each spent 30 years in a mental hospital (not an unusual length of stay prior to 1960) and 120 "nervous breakdown" patients each spent three months in the same mental hospital (also not unusual for this period). If the "nervous breakdown" patients entered the hospital sequentially over a 30-year period there would always be 10 "mentally ill" patients and only one "nervous breakdown" patient in the hospital at a particular time. From the perspective of a researcher, as well as the patients and hospital staff, the in-patient population would be correctly perceived as comprised predominantly of chronically mentally-ill patients. However, if one takes into account the incidence rate and looks at what happened over the 30-year period, the hospital would have treated 12 "nervous breakdown" patients for every one "mentally ill" patient. Grob's (1994) summary of a longitudinal study of all first admissions to Warren State Hospital between 1916 and 1950 indicates that these hypothetical data are pointing to a very real process. In Grob's (1994:188) words: "The large chronic population, however, tended to shield from sight a much larger group of patients who were admitted, treated, and discharged after relatively short lengths of stay."

LABELING AND PSYCHIATRIC CONCEPTIONS OF MENTAL ILLNESS

The Social Constructionist/Labeling Approach

Social constructionist/labeling theory focuses on how social institutions shape the understanding and treatment of people with mental problems, and thus how such institutions create career paths for those labeled mentally ill.

Goffman. The standard sociological account of the career of the mentally ill is Goffman's (1961) paper, "The Moral Career of the Mental Patient," which is based on his 1955–1956 study at St. Elizabeth's Hospital, is one of the largest mental hospitals in the United States—with over 7,000 patients. At that time, a substantial proportion of the resident patient population was confined in hospital wards for years, if not decades. These wards were highly structured social entities, and they played a major role in shaping the lives of patients.

In the nearly 50 years since Goffman's research, the structure and processes of psychiatric treatment have changed dramatically (e.g., the median length of hospitalizations is now approximately two weeks, patients have well-defined rights, and the previous ward system has disappeared), and Goffman's discussion of mental hospitalization is now largely of historic interest (Weinstein 1994). However, his framework continues to shape the way social scientists think about the hospitalization process.

According to Goffman's sociological perspective, being categorized as a mental patient alters a person's fate in fundamental ways, and this categorization occurs *"when, and only when, a person is put through the process of hospitalization"* Goffman (1961: 128). Goffman went on to discuss the first two phases of what he termed as the three phases of a career of the mental patient: the pre-patient phase, the in-patient phase, and the ex-patient phase. The process begins with a troubled person experiencing a "funnel of betrayal," in which family members and close associates cooperate with psychiatric authorities to undermine the person's legitimacy as a "normal" person and to facilitate the transformation of the person into one who is "mentally ill." Central to Goffman's view is that this transformation, which accompanies mental hospitalization, is both stigmatizing and debilitating.

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

Scheff's Labeling Theory. According to Scheff's (1984) position, deviant behavior that cannot be classified into a standard cultural category (crime, alcoholism, drug addiction, sexual deviance, etc.) is "residual rule-breaking." When such residual deviance comes to the attention of public officials, particularly mental health professionals, perpetrators are usually classified as mentally ill, and psychiatric treatment is almost always seen as the wisest course of action. Careers of the mentally ill are products of this process. As Scheff (1984:69) puts it in his concluding proposition, "*Among residual rule-breakers, labeling is the most important cause of careers of residual deviance.*" Put another way, among those who behave in unconventionally deviant ways, labeling (specifically psychiatric hospitalization) is an important cause of careers of mental illness.

Stigma and Labeling Theory. A critical issue in both Goffman's and Scheff's frameworks is stigma. Today, most social scientists would agree that when psychiatric patients are hospitalized most have a fairly serious disorder. However, there is no consensus on the degree to which the labeling or stigma of mental illness caused by being hospitalized poses a serious long-term problem for these patients. I have argued that most hospitalized mental patients experience stigma. However, it has been my position that, in the absence of a continuation of disturbed behavior, this stigma is almost always transitory, that it is unusual for it to cause serious long-term problems, and that it does not cause a career of secondary deviance (Gove 1982). This is not the dominant perspective in the field. For example, in their introduction to the *Handbook on the Sociology of Mental Health,* Aneshensel and Phelan (1999:4) assert that the evidence is compelling that, "Being identified as mentally ill is itself a social transformation. One's identity is altered, often irrevocably, and this transformation has profound repercussions for one's subsequent social relationships."

Summary. Scheff, Goffman, and other labeling theorists argued that psychiatric treatment, particularly hospitalization, was a key causal factor in the production of careers of stabilized secondary deviance. I argue that evidence such as that presented by Goffman was seriously biased because it was based primarily on observations of chronic, mostly long-term, patients, who comprise a relatively small proportion of all those hospitalized for mental disorder. Nevertheless, elements of Goffman's and Scheff's frameworks are valuable.

As Goffman strongly emphasizes, an important consequence of a psychiatric hospitalization for a mental patient is the acquisition of a new identity as someone who is experiencing serious mental and/or emotional difficulties. However, as indicated in the section on lay conceptions, this process does not necessarily define a person as "mentally ill." As Scheff pointed out, the symptoms of "mental illness" involve behaviors and mental states that are difficult to comprehend and label. In addition, residual rule-breaking is difficult to define because it typically includes some variation on common emotions and behaviors. Persons tend to normalize the extreme forms of these emotions and behaviors as they involve common experiences, and there is no definitive line that marks the transition from "normal" to "seriously disturbed."

The Psychiatric Conception of Mental Disorder

Psychiatrists are the gatekeepers who decide whether a patient is to be hospitalized. A number of elements in the psychiatric perspective are important for understanding careers of the mentally ill.

Categories of Mental Disorder. In 1980, the American Psychiatric Association published the third edition of the *Diagnostic and Statistical Manual of Mental Disorder (DSM III)*. Unlike the previous editions, this manual categorized explicit diagnostic criteria for different mental disorders. *DSM III* and its subsequent revisions (in *DSM IIIR* 1987, *DSM IV* in 1994 and *DSM IVR* in 1999) have had the pragmatic effect of indicating that psychiatry is a biomedical/scientific discipline (Wilson 1993; Horwitz 2002).

The categories standardize diagnostic criteria for all the disorders/problems that mental health professionals treat, with relatively little attention being paid to the validity of these categories. According to the critics of *DSM III-IV*, its presentation is based on a quasi-scientific foundation, it reifies disorders of questionable validity, and it medicalizes deviant behavior (Rogler 1997). Furthermore, Aneshensel and Phelan (1999:5) and other

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

sociologists take the position that the "hodge-podge quality [of the categories] in *DSM III-IV* means that the concept of mental illness is too amorphous to be useful except as a way of speaking about the conglomerate subject matter of psychiatry." Aneshensel and Phelan are correct regarding the disparate nature of the categories of the *DSM*. However, *DSM III-IV* is a classification system for mental disorders and not mental illness. Persons who want a definition of "mental disorder" should look at the introductory statement in *DSM III-IV*. The term "mental illness" is never used in the text of the manual.[1] This fact, often overlooked, underscores what Goffman, Scheff, and other labeling theorists have shown; *mental illness is a lay construct and not a diagnostic category used by psychiatry.* However, several other elements of the psychiatric perspective are directly relevant for understanding careers of mental illness, and it is to these that we now turn.

Stress. A fundamental premise of persons working in psychiatry and medical sociology is that a high level of stress causes high levels of distress and is related to a wide variety of other disorders (Turner 2003). Where sociologists focus almost exclusively on the stress process, including both stress and coping, psychiatrists are attentive to the interplay of stress and its biological attributes.

Symptoms and Impairment. If persons who occupy normal societal roles undergo periods of prolonged or very high levels of stress, they may experience acute mental/emotional problems. Persons respond to these problems in a variety of ways, including seeking help from mental health professionals. I take the position that the painful emotions, the cognitive symptoms, and the impaired behavior associated with such problems are the key determinants of the process that leads to treatment, including hospitalization. In most cases the symptoms are transitory and psychiatric treatment is often effective in bringing the psychiatric symptoms under control. Assuming these persons are already competent in the skills necessary to function effectively within the community, most of them will experience only a transitory disorder.

Schizophrenia. Schizophrenia is the disorder that has the closest correspondence to what the lay public sees as mental illness. Persons with schizophrenia often lead a marginal existence largely due to their inability to function in a normal manner and, as a consequence, are disproportionately found in the lowest class (Dohrenwend et al. 1992). Our understanding of schizophrenia is in the process of undergoing a major transformation. For example, it is now known that a large number of genes are linked to schizophrenia. The nature of these genetic links is a complex unsolved puzzle (e.g., Sawa and Synder 2002; Kennedy et al. 2003).

It was once thought that the active (psychotic) symptoms of schizophrenia would be the most difficult to treat. However, there are negative symptoms of schizophrenia, such as restricted emotional intensity (affect flattening), diminished fluency and productivity of thought and speech (alogia), and an inability to initiate and persist in goal-directed activities (avolution). These negative symptoms are the symptoms most difficult to treat. For a discussion of programs that attempt to treat these impairments see Pickett, Cook, and Rozzano (1999).

Affective Disorders. The disorders that would appear to most closely correspond to the lay concept of a nervous breakdown are the affective disorders. The impairment of persons with affective disorders has received less attention than schizophrenia. But as numerous studies have shown (e.g. Kessler and Frank 1997; Kessler, Walters and Forthofer 1996; Simon 2003), the manifestation of a major affective disorder is associated with a substantial impairment in a person's performance.

Re-hospitalization. A number of hospitalizations are actually re-hospitalizations. The deinstitutionalization movement, which started in the 1950s, led to the gradual transfer of patients in large public hospitals to poorly developed mental health care systems in the community. One of the consequences of these changes is that a small subset of patients cycle in and out of public mental hospitals, with each stay being fairly short (Cook and Wright 1995; Leginski, Manderscheid and Henderson 1987). For example, Kreisman and Joy (1974) found that in public mental hospitals in New York State more than 60 percent of patients were readmissions. Using a career perspective, multiple hospitalizations are an indicator of chronicity that is both similar to, and different from, the prolonged hospitalizations of chronic patients that occurred in the past. These multiple hospitalizations should be taken as episodic indicators of chronicity, and they should not

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

be confused with the incident rate described above.

Summary. Psychiatrists, who play the key role in determining whether a psychiatric hospitalization is required, make their decisions based on their assessment of a person's mental disorder. Social scientists need to be attentive to the fact that mental illness is a lay construct and not a psychiatric category. The symptoms associated with schizophrenia roughly correspond to what the public sees as mental illness. There is substantial evidence that persons with schizophrenia have a high level of functional impairment, and this impairment is often present when psychotic symptoms are not present. The affective disorders have the symptoms that tend to be closer to the public's perception of a nervous breakdown. An acute episode of an affective disorder is also associated with high levels of impairment.

THE "CAREER OF THE MENTALLY ILL": A REVISED FRAMEWORK

Elements of the lay perspective, the labeling/social constructionist perspective, and the psychiatric perspective can be incorporated in examining Goffman's three phases of the "career of the mentally ill": pre-patient, in-patient, and post-patient.

The Pre-Patient Phase

The Path to In-Patient Psychiatric Treatment. As Braginsky et al. (1969) and Emerson (1981) hold, mental hospitalization is socially defined as an act of last resort. Hospitalizations are presumed to occur because of the failure of all other remedies and/or the perception that other remedies are inadequate because of the seriousness of the problem. This is true for persons who voluntarily seek treatment and for the patient who has applied for admission because of the persuasion, threats, and ultimatums of others. It is also true for the next-of-relations and others who are close to the person and have been experiencing the havoc and pain that comes from dealing with the disturbed person and, as a consequence, play a key role in the hospitalization process.

Persons using the labeling/constructionist and psychiatric perspectives agree that the troubles of mental disorders typically unfold in an uneven, unpredictable manner, with only a very few cases ultimately resulting in mental hospitalization. However, being able to provide a descriptive overview of this process does not provide an explanation of why particular acts occur. For example, the literature indicates that persons who have a close relationship with someone who is disturbed are more likely to normalize disturbed symptoms than are persons who do not have a relationship with that person (Horwitz 1982:35–47 and Pescosolido et al 1999:445). The literature also indicates that it is the persons close to the prospective patient who play a critical and often coercive role in initiating the hospitalization process. However, we do not have a clear understanding of why such persons are also those who are 1) the most likely to normalize the disturbed behavior, and 2) usually the most concerned with the well-being of the prospective patient.

We now turn to the question: How does our understanding of the pre-patient phase change when the lay concepts of "nervous breakdowns" and "mental illness" are incorporated?

Framing Behavior. According to Goffman (1974), our understanding of situations is made possible by *frames*, shared principles that organize our understanding of situations and our involvement in them. Within frames are *scripts,* shared understandings of sequences of interaction that guide behavior and enable individuals to interact with each other effectively. Goffman's framework provides another way to understand Scheff's notion of residual deviance. Behaviors that do not make sense in the context of the frame are incomprehensible. Although there are frames and various scripts for the mental patient starting at the time he or she applies for psychiatric treatment or someone initiates commitment proceedings, everyday life provides no frame or set of scripts that actually directs one toward this course of action.

Normalization. When a person is seriously disturbed and acting in ways that are outside frames and scripts, others involved in the situation will try to make sense of these behaviors. Given that the existing frame calls for normal behavior, others try to normalize the disturbed behavior. Furthermore, others will expend considerable effort to make troublemakers appear normal because it keeps the situation defined as normal and allows others to interact in a normal fashion (Lynch 1983)

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

Characteristics of Symptoms. Taken individually, most of the symptoms of a "nervous breakdown" and "mental illness" are quite common. Being very depressed, anxious, irritable, and angry are normal reactions to the difficult experiences that are an intrinsic part of our lives (Thoits 1984). Furthermore, almost everyone will, on occasion, manifest these feelings in inappropriate ways. It is not unusual for persons to be fixated on notions that others may see as strange or even bizarre, nor is it uncommon for normally functioning persons occasionally to be unfocused and ineffectual (e.g., to be "out of it" or "not on track"). Psychotic symptoms are, in fact, common experiences among persons who are sleep deprived, have pushed themselves to their limits, and are engaged in a number of other situations such as drug use or having high levels of stress (Gove, 1970). As these symptoms are common, their manifestation is relatively easy to normalize in situations where normal behavior is expected to occur.

Normalizing the disturbed behavior of these individuals does not mean these individuals are perceived as problem-free. On the contrary, the closer others are to a disturbed individual, the more problems they perceive the individual as having. The disturbed individual perceives himself or herself as having the most problems (Whitt and Meile 1985). Those close to the disturbed person are the only persons having sufficient concern and authority to effectively channel the individual toward the necessary treatment, particularly if that treatment is a psychiatric hospitalization.

When an individual is overwhelmed by emotional pain and an inability to function, the symptoms they manifest will typically be seen as corresponding to a nervous breakdown. Persons who feel as if they are *about* to have a nervous breakdown typically seek some form of help (Thomas 1984; Swindle et al. 2000; Gove and Evenson 2003). These individuals use a variety of ways to deal with their problems and, with time, most are reasonably successful in dealing with their problems. However, if their attempts to deal with their problems are unsuccessful, the problems persist, their situation may get increasingly difficult, and they may reach a point where they are truly out of control. At this point, the individual is typically perceived as having a "nervous breakdown," and hospitalization may occur.

However, given the nature of the lay perspective, when hospitalization is perceived to being due to a "nervous breakdown" the stigma will not be nearly as strong as it would be if the person was perceived as being "mentally ill." I hypothesize that this perception plays a major role in explaining why many persons may be willing to go to a hospital and why persons close to patients are willing to play a key role in the hospitalization process. In short, the lay concept of a nervous breakdown frequently plays an important role in facilitating the hospitalization process.

The In-Patient Phase

I now turn to the cases where attempts at normalization and non-drastic forms of intervention fail (e.g., outpatient treatment) and hospitalization occurs.

Becoming a Mental Patient. The labeling/social constructionist perspective holds that hospitalization designates a person as being "mentally ill." When this occurs the individual acquires a highly stigmatized master status that indicates he or she cannot be trusted, is likely to be irrational, and may sometimes be dangerous. As a consequence of this status a person is likely to have a career of secondary deviance. In this view, mental health professionals play the pivotal role by exercising their legally and socially legitimated authority to define people previously assumed to be "normal" as "mentally ill," and to decide whether hospitalization is necessary. Thus, at the pragmatic level, psychiatrists "create mental illness." Their acts define and bracket the chaos that is being manifested, determine how that chaos is to be understood, the nature of roles of the various parties involved, and how that chaos is to be controlled.

Does Mental Hospitalization Signify That One is Mentally Ill? Being hospitalized for a mental disorder is intrinsically stigmatizing because it signifies that one is unable to cope with stress and is having emotional and behavioral problems so serious that they cannot be dealt with while one is in the community. Mental hospitalization thus affects one's self-perception, the perception of relevant others, and, in turn, the patient's perception of how he or she is being perceived. Even if one is perceived as having a "nervous breakdown," in the lay conception of mental problems, the boundary between a "nervous breakdown" and

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

"mental illness" is not sharply delineated, and, for some, a "nervous breakdown" may be a stage in the development of "mental illness." Thus, when persons are hospitalized for what appears to be a "nervous breakdown," *they and others frequently fear that their "nervous breakdown" may turn out to be a precursor to "mental illness."* As a consequence neither the patient nor others can be certain that an "illness" which results in mental hospitalization is a "nervous breakdown" and not "mental illness" until it is clear the person has recovered.

The evidence shows that although most patients perceive themselves as needing treatment, they do not see themselves as "mentally ill." The denial of "mental illness" is possible because, in their identity work, persons are able to use the lay distinction made between a "nervous breakdown" and "mental illness" (e.g. Lopez and Guarnaccia 2000). This identity work is clearly described by Townsend and Rackfelt (1985) in their study of first contact hospitalized mental patients. Only eight percent of the patients accepted the definition that they were mentally ill; the other patients defined themselves as not "mentally ill" by contrasting their symptoms with those stereotypically associated with "mental illness."

If one is perceived as having a "nervous breakdown," one can derive certain benefits from the setting and symbolism associated with mental hospitalization. First, fundamental to the "nervous breakdown" model is the premise that they occur when a person has been mentally, emotionally, and physically overwhelmed by the problems and turmoil of one's life. Many mental patients experience the hospital as a place where one is cared for, has minimal obligations, and is free from the troubles of daily life (Weinstein 1982; Grob 1994). Thus, mental hospitals are often experienced literally as an asylum. Second, for those close to the patient, hospitalization transforms a troublesome person who had become intolerable into someone who is ill, not responsible for past problematic behaviors, and who needs support and care (Gove 1980). Third, it is expected that, in most cases, persons experiencing a nervous breakdown will return to normal levels of functioning.

By incorporating the lay concept of the "nervous breakdown" into the description of the in-patient phase of the course of "mental illness" we gain a better understanding of why most patients escape a career of secondary deviance and return to normal functioning after an episode of hospitalization.

Post-Patient Phase

Just as no established path leads to psychiatric treatment, no established path leads to re-attaining normality, nor is there a clearly developed script that socially certifies one is now "normal." However, most persons who have been psychiatrically hospitalized get better and re-attain the status of being "normal." This is particularly true of persons who have a history of normality, have adequate social and instrumental skills, and have been relatively well integrated into the community, although this transition is not an easy one. The lay concepts of "nervous breakdown" and "mental illness" create frames for examining post-discharge issues.

Confusion over Definitions of the Situation. During the early phases of the transition period, people associated with the former patient do not know how they should act or what they should expect from the person re-entering the world of "normal." They are uncertain and frequently confused over whether they are interacting with the original "troublesome person," the "person requiring hospitalization," or a person who has been "cured." Furthermore, both the ex-patient and those close to the ex-patient will have constructed a definition of past situations and the behaviors that have occurred, and these definitions tend to linger and confuse interactions between the patient and those close to him or her. Common concerns include the ex-patient's past behavior, the situations and events that precipitated hospitalization, the way hospitalization came about, perceived results of hospitalization, and the nature of changes in the situation and behavior that may or may not be occurring. For both the ex-patient and others, this is a time of negotiation and testing.

Pivotal to the experiences of a newly-discharged patient are the social definitions of the patient's disorder. Do others and the ex-patient perceive the disorder as a transitory reaction to an overload of stress? Are persons afraid that the ex-patient will be unable to cope with the problems of life? Do others view the ex-patient as someone who is going to be chronically mentally ill?

Change in the Normalization Process. Prior

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

to someone being effectively labeled "ill," normalization means that manifestations of "psychiatric symptoms" are perceived as the reactions of normal individuals reacting in a very problematic fashion. Once a person has been defined as "ill" by being hospitalized, the normalization process changes such that relatively modest levels of depression, anxiety, agitation and dysfunctional cognitive behavior indicate that individual is still "ill."

Continuation of Treatment. Although the transition to normality begins with discharge from the hospital, the ex-patient almost always continues treatment. This continuation can interfere with achieving "normality" in important ways. For example, heavy dosages of medication may have been prescribed, and such dosages may impair the person's ability to function effectively. Furthermore, the presence of and reliance on various forms of therapy blurs the transition to normality even among individuals who are able to function in a normal manner.

Relapse. Persons in the process of re-acquiring "normal" status following their hospitalization are rarely as stable as most individuals. Relapses, both minor and serious, are common, and their occurrence increases uncertainty regarding the ex-patient's ability to avoid trouble in the future. The level of uncertainty may be strongly affected by how the ex-patient's disorder is perceived.

Script for Re-Hospitalization. Although there is no frame or script that leads to first hospitalization, being hospitalized creates a frame and script leading to re-hospitalization. Re-hospitalizations increase the likelihood of secondary deviance.

Stigma. That there is stigma associated with mental illness is clear (Link et al. In Press). How that stigma affects particular persons who have had a psychiatric hospitalization is far from clear. For example, persons hospitalized for a "nervous breakdown" and perceived as having been hospitalized for a nervous breakdown would appear to escape much of the stigma associated with mental illness. The literature consistently indicates that persons who are fairly close to persons who have had a mental hospitalization report being more comfortable around such persons than are persons who *believe* they do not know persons who have had a mental hospitalization (it is an experience persons usually avoid talking about). However, the literature indicates that when persons are actually interacting with someone who manifests a pattern of normal behavior, they tend not to reject that person just because the person has had a mental hospitalization (Gove 1980). In contrast, if persons act in a problematic manner they tend to be discriminated against. This is particularly true if they have already been labeled by being hospitalized.

Doubts about Self. Persons who are hospitalized for what they see as a "nervous breakdown" have been emotionally and physically overwhelmed and are unable to function. *This failure tends to be more strongly felt by the individuals who are hospitalized than it is by others.* After all, the patient is the one who has been hospitalized, experienced the emotional distress, been out of control and unable to cope, and been socially defined as a person whose disorder is responsible for the havoc that occurred prior to hospitalization (Huffine and Clausen 1979; Clausen 1981). Such persons may also fear discrimination, and they may keep their stigmatizing experiences a secret to avoid situations they view as problematic and threatening. This self-monitoring inhibitive behavior is a normal and common way of dealing with undesirable information about oneself. In fact, it would be surprising if person who had been a hospitalized mental patients did not utilize this strategy. At the same time, overuse of this strategy can lead to substantial restriction of opportunities and activities. This is frequently an issue for persons making the transition from the hospital to the community. Link (1982; 1987) and Link et al. (1989) have argued that this self-monitoring inhibitive behavior is a major cause of secondary deviance. However, a psychiatric perspective provides a more complete and parsimonious explanation for the relationships presented in their papers.[2]

Re-Attaining the Status of Normal. Persons using the labeling/social construction perspective do not address the issue of how persons reattain the status of normal. The psychiatric model presumes that with time and treatment most persons get better, but it does not address the issue of identity and how one re-obtains the status of normality. The nervous breakdown model provides an explanation of the nature and course of the disorder for the lay person, and it assumes that if a "time-out period" is provided to facilitate help for troubled people, most individuals will be able to return to a state

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

where they can function normally. However, certification that a treated person is now "normal" is difficult to achieve until a person has re-established a clear and prolonged pattern of normal behavior. Such certification requires a retrospective position.

The Chronically Disturbed. An underlying premise of this paper is that there are a substantial number of persons who chronically occupy the role of the mentally ill. These persons have received most of the attention in various studies of psychiatric hospitalization; these studies tell us much of what we know about the experiences of the chronically mentally ill (e.g. Estroff 1981; Link et al.1997; Link et al. 2002; Rosenfield 1997; Wright, Gronfien, and Owens 2000). This research indicates that the chronically mentally ill lead stigmatized lives, that innovative programs focused on providing them with social and instrumental skills can improve the quality of their lives (Simon 1997; Link et al, 1997), that rejection experiences are more problematic than concerns about rejection (Link et al. 1997), and that training on how to deal with stigma has little effect on how stigma is experienced (Link et al. 2002). All of these studies focus on persons who lack the instrumental and social skills to function in society, who have multiple hospitalizations, and whose life history reflects a marginal lifestyle that is integrally tied to a chronic disorder. However, the majority of persons who are hospitalized are hospitalized for acute transitory disorders, and it is not clear how this literature on the chronically mentally ill is relevant to understanding the experiences of persons with an acute transitory disorder. This issue needs additional study.

Summary. Most persons who are treated in a mental hospital have a transitory disorder and they return to normal in societal roles where they function in a normal manner. A few persons do not. The period following hospitalization is a difficult one, and there are a number of processes that tend to promote secondary deviance. As a consequence of these processes and the nature of mental disorders, the path back to normality is an uneven one; the ex-patient and others involved often feel unsure about the trajectory he or she is on. The social definition that normality has been re-obtained requires a retrospective position where one can look back and 'see" that a person has performed in a normal manner over a substantial period of time. A positive attribute of the nervous breakdown model is that it provides a definition of the situation that facilitates the reattainment of normality in a variety of ways, and it avoids the problems associated with being socially defined as "mentally ill."

CONCLUSION

Elements of both the labeling and the psychiatric perspectives are necessary to understand the nature and course of mental disorder. But both also miss a variety of issues that are essential if one is to understand the career of the "mentally ill." A fundamental premise of this paper is that "mental illness" and "nervous breakdowns" are lay constructs that attempt to make sense of particular kinds of empirical realities. Distinguishing between "nervous breakdowns," "mental illness," and the "archetypal case of the mentally ill" make it possible to explain a set of counterintuitive but robust findings that have previously lacked a theoretical explanation, namely, why most hospitalized mental patients (1) view themselves as needing and benefiting from hospitalization, (2) do not view themselves as "mentally ill," (3) can maintain a negative stereotype of "mental illness," and (4) do not progress to a career of secondary deviance.

To develop an accurate understanding of the "career of the mentally ill," we must attend to lay conceptions of mental disorders. Folk illnesses similar to a "nervous breakdown" and "mental illness" occur across a wide array of cultures. Furthermore, the fact that severely depressed persons in different cultures actively use the distinction between the cultural equivalent of a nervous breakdown and mental illness to minimize the stigma they experience indicates the importance placed on not being perceived as mentally ill and of the social utility of the construct of a nervous breakdown. Thus, as Kleinman (1988), Guarnaccia (1993) and others (e.g., see Kleinman and Good 1985; Fabrega 1992) have persuasively argued, in order to understand a disorder and to treat it in an effective manner, one needs to know how mental (and physical) disorders are perceived by the persons involved.

Persons who self-diagnose themselves as having a "nervous breakdown" are actively using the distinction between a "nervous breakdown" and "mental illness" (or for exam-

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

ple "ataques de nervios" and "locura" [enduring madness]) (Guarnaccia et al. 1992: 194; also see Kleinman and Good 1985) to construct a personal and social definition that they are not "mentally ill." The lay notion of a "nervous breakdown" provides an important identity tool that persons use to maintain a relatively positive self-definition and to minimize the stigma associated with a psychiatric hospitalization.

The career of the mentally ill must be understood as a process which unfolds in an unpredictable ways, and the nature of a particular outcome can be known only from a retrospective position. In this paper, I have argued that the symptoms of a "nervous breakdown" and "mental illness" are normal experiences. They become indicators of "illness" not because they are unique, but because of their persistence, severity, and socially inappropriate manifestation. Before hospitalization, these problematic behaviors are perceived as indicating one is a troublesome person. Hospitalization redefines those behaviors and indicates that one is "ill" and in need of help. However, the processes that result in hospitalization are very complex, and only a few persons who are having "trouble" end up being hospitalized. It appears that the persons who are hospitalized tend to be those with a severe disorder, but the processes that result in a few persons being hospitalized while most are not are not well understood, and the necessity of hospitalizing a particular individual can be known only from a retrospective position. Most hospitalized mental patients appear to (re)attain the status of "normal." However, some persons are chronically disturbed, and it is difficult to accurately predict the future of a particular patient. Thus, at the time of hospitalization one cannot know if that psychiatric hospitalization is going to be a transitory episode in the life of that individual or if it is the beginning of a deviant career.

Although being discharged from a hospital is an important step towards being defined as recovered, it usually does not define one as "normal." In the post-hospitalization period a number of processes make it difficult to acquire the status of "normal." Persons who have been discharged typically go through a rough period, and during this time, the trajectory of that person's disorder often undergoes a great deal of fluctuation. As a consequence, the social definition that one is now "normal" can be attained only from a retrospective position.

Research on the "career of the mentally ill" must be expanded to include a greater focus on (1) the processes that result in some persons, but not others, experiencing psychiatric hospitalization; (2) the processes of (re)definition of self that occur during and after hospitalization; and (3) the processes by which some hospitalized persons, but not others, (re)attain the status of "normality." What is known almost always comes from persons who not only have entered treatment but have also been hospitalized, despite the fact that the vast majority of persons who start down the path are not hospitalized. Thus, there is little information about the processes that lead some persons but not others to be hospitalized. To understand this stage, we need to study the pathways taken by those persons who are not hospitalized and those who are. Little is known about the ways in which psychiatric patients, and persons close to patients, conceptualize their disorder, and what we do know is largely limited to persons treated in institutional settings readily accessible to researchers. The lack of knowledge about the post-hospital "career of the mentally ill" is even greater. Research on the factors affecting the individual's self-definition before, during, and after hospitalization is sorely needed.

Most of what we know about the career of the mentally ill comes from persons who have been hospitalized and have not been successful in making a transition back to the community. In part, this is due to the fact that it is very difficult for researchers to obtain access to the primary providers of treatment for persons with acute transitory disorders, namely private psychiatric hospitals and most psychiatric wards in general hospitals. It also reflects the fact that the only places where one can find a relatively large stable pool of mental patients are public mental hospitals and community centers that provide intensive long-term care. Due to these limitations, the literature presently provides a distorted view of the career of most persons who have a psychiatric hospitalization.

NOTES

1. The preface of *DSM IV* does use the term "mental illness" when referring to the diag-

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

nostic categories used in the 1880 census (p. xvii).

2. A comparison of the psychiatric and labeling explanations of the relationships in these papers is available upon request.

REFERENCES

Aneshensel, Carol S. 1999. "Mental Illness as a Career: Sociological Perspectives." Pp. 585–603 in *Handbook of the Sociology of Mental Health*, edited by C. Aneshensel and J.C. Phelan. New York: Kluwer Academic/Plenum.

Aneshensel, Carol S. and Jo C. Phelan. "The Sociology of Mental Health: Surveying the Field." Pp. 3–17 in *Handbook of the Sociology of Mental Health*, edited by C. Aneshensel and J. C. Phelan. New York: Kluwer Academic/Plenum.

Askanasy, A. 1974. *Attitudes Toward Mental Patients: A Study Across Cultures*. Hague, Holland: Mouton.

Baer, Roberta D., Susan C. Weller, Javier Garcia de Alba Garcia, Mark Glazier, Robert Trotter, Lee Pachter, and Robert E. Klein. 2003. "A Cross-Cultural Approach to the Study of the Folk Illness Nervios." *Culture, Medicine and Psychiatry* 27:315–337.

Braginsky, Benjamin, Dorothea Braginsky, and Kenneth Ring. 1969. *Methods of Madness: The Mental Hospital as Last Resort*. New York: Holt, Rinehart and Winston.

Clausen, John. 1981. "Stigma and Mental Disorder: Phenomena and Terminology." *Psychiatry* 44:287–96.

Cook, Judith A. and Eric R. Wright. 1995. "Medical Sociology and the Study of Severe Mental Illness: Reflections on Past Accomplishments and Directions for Future Research." *Journal of Health and Social Behavior* (Extra Issue):95–114.

Dohrenwend, B.P., I. Levav, P.E. Shrout, S. Schwartz, G. Naveh, B.G. Link, A.E. Skodol, and A. Stueve (1992). "Socioeconomic status and psychiatric disorders: The causation-selection issue." *Science* 255:946–52.

Emerson, Robert. 1981. "On Last Resorts." *American Journal of Sociology* 87:1–22.

Estroff, Sue E. 1981. *Making It Crazy*. Berkeley, California: University of California Press.

Fabrega, Jr., Horacio. 1992. "Cultural Challenges to the Psychiatric Enterprise." *Comprehensive Psychiatry* 36: 377–383.

Goffman, Erving. 1961. *Asylums*. New York: Anchor.

———. 1974. *Frame Analysis*. New York: Harper.

Gove, Walter R. 1970. "Sleep Deprivation: A Cause of Psychotic Disorganization." *American Journal of Sociology* 75:782–99.

———. 1980. "Labeling Mental Illness: A Critique and Postscript." Pp. 53–110 in *The Labeling of Deviance: Evaluating a Perspective* (Second Edition), edited by Walter R. Gove. Beverly Hills, California: Sage Publications.

———. 1982. "The Current Status of the Labeling Theory of Mental Illness." Pp. 273–300 in *Deviance and Mental Illness*, edited by Walter R. Gove. Beverly Hills, California: Sage.

Gove, Walter and Renae Evenson. 2003. "What it Means to Have a Nervous Breakdown." presented at annual meeting of the Southern Sociological Society. New Orleans. March.

Gove, Walter and Patrick Howell. 1974. "Individual Resources and Mental Hospitalization: A Comparison and Evaluation of the Psychiatric and Societal Reaction Perspectives." *American Sociological Review* 39:80–100.

Gove, Walter, Michael Hughes and Maurizia Tovo. 1985. "Involuntary Psychiatric Hospitalization: A Review of the Statutes Regulating the Social Control of Mental Illness." *Deviant Behavior* 6:287–318.

Grob, Gerald N. 1994. *The Mad Among Us: A History of the Care of America's Mentally Ill*. New York: Free Press.

Guarnaccia, Peter J. 1993. "*Ataques De Nervios* in Puerto Rico: Culture-Bound Syndrome or Popular Illness?" *Medical Anthropology* 15:157–70.

Guarnaccia, Peter J., Roberto Lewis-Fernandez, and Melissa Revera Marano. 2003. "Toward a Puerto Rican Popular Nosology: *Nervios* and *Ataques de Nervios*." *Culture, Medicine and Psychiatry* 27: 339–366.

Guarnaccia, Peter J., Pilar Parra, Aura Deschamps, Glen Milstein and Nuri Argiles. 1992. "*Si Dios Quiere:* Hispanic Families' Experiences of Caring for a Seriously Mentally Ill Family Member." *Culture, Medicine and Psychiatry* 16:187–215.

Gurin, G., J. Veroff and S. C. Feld. 1969. *Americans View Their Mental Health*. New York: Basic Books.

Helmuth, Laura. 2003. "In Sickness or in Health?" *Science*. 302:808–10.

Hodgins, Sheilagh (ed.). 1993. *Mental Disorder and Crime*. Newbury Park, California: Sage Publications, Inc.

Hollingshead, August and Frederick Redlick. 1958. *Social Class and Mental Illness*. New York: John Wiley.

Horwitz, Allan V. 1982. *The Social Control of Mental Illness*. New York: Academic Press.

———. 2002. *Creating Mental Illness*. Chicago: University of Chicago Press.

Huffine, Carole and John Clausen. 1979. "Madness and Work: Short-and-long-term Effects of Mental Illness on Occupational Careers." *Social Forces* 57:1049–62.

Hughes, Michael and W. Gove. 1981. "Status Resources and Mental Hospital Commitment in

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

Tennessee 1956–1965: A Reexamination." Southern Sociology Society. Lexington, Kentucky. April.

Karp, D.A. 1996. *Speaking of sadness: Depression, disconnection, and meanings of illness*. Oxford: Oxford University Press.

Keith, Samuel J., Darrel A. Regier, and Donald S. Rae. 1991. "Schizophrenic Disorders." pp33–52. Lee Robins and Darrel A. Regier, editors. *Psychiatric Disorders in America: The Epidemiologic Catchment Area Studies*. New York: The Free Press.

Kennedy, J.L., L.A. Farrer, N.C Andreasen, R. Mayeux, and P. St. George-Hyslop. 2003. "The Genetics of Adult Onset Neuropsychiatric Disease: Complexities and Conundra?" *Science* 302: 822–6.

Kessler, Ronald C. and Richard G. Frank. 1997. "The Impact of Psychiatric Disorders on Work Loss Days." *Psychological Medicine* 27:861–873.

Kessler, Ronald C., Ellen E. Walters, and Melinda S. Forthofer. 1998. "The Social Consequences of Psychiatric Disorders, III: Probability of Marital Stability." *American Journal of Psychiatry* 155:1092–1096.

Kleinman, A. 1986. *The Social Origins of Distress and Disease.* New Haven: Yale University Press.

Kleinman, A., and B. Good (eds.). 1985. *Culture and Depression.* Berkeley, California: University of California Press.

Kreisman, Dolores E. and Virginia D. Joy. 1994. "Family Response to the Mental Illness of a Relative: A Review of the Literature." *Schizophrenia Bulletin* 10: 34–53.

Leginski, Walter A. Ronald Manderscheid and Paul Henderson. 1987. Pp. 173–95 in *Mental Health, United States, 1987* edited by R. Manderscheid and S. Barrett. National Institute of Biometry and Applied Science. Washington, D.C.: U.S. Government Printing Office.

Link, Bruce G. 1982. "Mental Patient Status, Work, and Income: An Examination of the Effects of a Psychiatric Label." *American Sociological Review* 47: 202–215.

———1987. "Understanding Labeling Effects in the Area of Mental Disorders: An Empirical Assessment of the Effects of Expectation of Rejection." *American Sociological Review* 52:96–112.

Link, Bruce G., Howard Andrews, and Francis Cullen. 1992. "The Violent and Illegal Behavior of Mental Health Patients Reconsidered." *American Sociological Review* 57:275–92.

Link, Bruce G., Francis T. Cullen, Elmer Struening, Patrick E. Shrout, and Bruce P. Dohrenwend. 1989. "A Modified Labeling Theory Approach to Mental Disorders: An Empirical Assessment." *American Sociological Review* 54:400–23.

Link, Bruce G., Michael Rahav, Jo C. Phelan, and Larry Nuttbrock. 1997. "On Stigma and Its Consequences: Evidence from a Longitudinal Study of Men with Dual Diagnoses of Mental Illness and Substance Abuse." *Journal of Health and Social Behavior* 38: 177–190.

Link, Bruce G., Elmer L Struening, Sheree Neese-Todd, Sara Asmussen, Jo C. Phelan. 2002. "On Describing and Seeking to Change the Experience of Stigma." *Psychiatric Rehabilitation Skills* 6:201–231

Link, Bruce.G., L.H. Yang, Jo C. Phelan, P.Y. Collins. (In press). "Measuring Mental Illness Stigma," *Schizophrenic Bulletin.*

Lopez, Steven Regeser and Peter J.J. Guarnaccia. 2000. "Cultural Psychopathology: Uncovering the Social World of Mental Illness." *Annual Review of Psychology* 51: 571–598.

Lynch, Michael. 1983. "Accommodation Practices: Vernacular Treatments of Madness." *Social Problems* 31:152–164.

Manderscheid, Ronald and Marilyn J. Hender. 2001. *Mental Health, United States, 2000.* National Institute of Mental Health, Division of Biometry and Applied Science. Washington, D.C.: U.S. Government Printing Office.

Manderscheid, Ronald and Mary Anne Sonnenschein. 1992. *Mental Health, United States, 1992.* National Institute of Mental Health, Division of Biometry and Applied Science. Washington, D.C.: U.S. Government Printing Office.

Martin, Jack K., Bernice A. Pescosolido, Steven A. Tuch. 2000. "Of Fear and Loathing: The Role of 'Disturbing Behavior,' Labels, and Causal Attributions in Shaping Public Attitudes Toward People With Mental Illness." *Journal of Health and Social Behavior* 41: 208–223.

Monahan, J. 1992. "Mental Disorder and Violent Behavior: Perceptions and Evidence." *American Psychologist* 47: 511–21.

Murphy, Jane. 1976. "Psychiatric Labeling in Cross-Cultural Perspective." *Science* 191:1019–28.

Pescosolido, Bernice A. Carol A. Boyer, and Keri M Lubell. 1999. "The Social Dynamics of Responding to Mental Health Problems." Pp. 441–460 in *Handbook of the Sociology of Mental Health* edited by C. Aneshensel and J. C. Phelan. New York: Kluwer Academic/Plenum.

Phelan, Jo C., Bruce G. Link, Ann Stueve, Bernice A. Pescosolido. 2000. "Public Conceptions of Mental Illness in 1950 and 1996: What is Mental Illness and Is It to be Feared?" *Journal of Health and Social Behavior* 41:188–207.

Pickett, Susan A., Judith A. Cook, and Lisa Razzano. 1999. "Psychiatric Rehabilitation Services and Outcomes: An Overview." Pp 484–492 in *A Handbook for the Study of Mental Health* edited by A. Horowitz and T. Scheid. Cambridge: Cambridge University Press.

Rabkin, Judith. 1980. "Determinants of Public Attitudes about Mental Illness: Summary of the

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions

Research Literature." Pp. 15–26 in *Attitudes Toward the Mentally Ill: Research Perspectives* edited by J. Rabkin, L. Gelbland, and J. Lazer. National Institute of Mental Health, Science Reports Branch, Washington, D.C.: U.S. Government Printing Office.

Redick, Richard W., Morton Kramer, and Carl A. Taube. 1973. "Epidemiology of Mental Illness and Utilization of Psychiatric Facilities Among Older Persons." Pp. 199–231 in *Mental Illness in Later Life* edited by E. Busse and E. Pfeiffer. American Psychiatric Association.

Rogler, Lloyd H. 1997. "Making Sense of Historical Changes in the Diagnostic and Statistical Manual of Mental Disorders: Five Propositions." *Journal of Health and Social Behavior* 38: 9–20.

Rogler, Lloyd H. and Dharma E. Cortes. 1993. "Help-Seeking Pathways: A Unifying Concept in Mental Health Care." *American Journal of Psychiatry* 150:554–61.

Rosenfield, Sara. 1997. "Labeling Mental Illness: The Effects of Received Services and Perceived Stigma on Life Satisfaction." *American Sociological Review* 62: 660–72.

Sawa Akira and Solomon H. Snyder. 2002. "Schizophrenia: Diverse Approaches to a Complex Disease." *Science* 296: 692–695.

Scheff, Thomas J. 1984. *Being Mentally Ill: A Sociological Theory* (Second Edition). New York: Aldine.

Simon, G. E. 2003. "Social and Economic Burden of Mood Disorders." *Biological Psychiatry* 84:208–215.

Strauss, John S., K. Ruben Gabriel, Ronald F. Kokes, Barry A. Ritzler, Autumn van Ord, and Elaine Tarana. 1979. "Do Psychiatric Patients Fit Their Diagnoses? Patterns of Symptomatology as Described with the Biplot." *The Journal of Nervous and Mental Disease 167:105–13.*

Swindle, Jr. Ralph., Kenneth Heller, Bernice Pescosolido, and Saeko Kikuzawa. 2000. "Responses to Nervous Breakdowns in American Over a 40-Year Period." *The American Psychologist* 55:140–149.

Thoits, Peggy A. 1984. "Coping, Social Support, and Psychological Outcomes: The Central Role of Emotion." Pp. 219–38 in *Review of Personality and Social Psychology,* vol. 5, edited by P. Shaver. Beverly Hills, California: Sage.

Thomas, Richard. 1984. "Mental Patient Career and Alternate Coping Techniques." Unpublished Dissertation. Vanderbilt University.

Torrey, E. Fuller. 1988. *Nowhere To Go*. New York: Harper and Row.

Townsend, John and Jack Rackfelt. 1985. "Hospitalization and First-Contact Mental Patients: Stigma and Change in Self-Concept." Pp. 269–301 in *Research and Community Mental Health*, vol. 5, edited by J.Greenley. Greenwich, Connecticut: JAI Press.

Turner, R. Jay. 2003. "The Pursuit of Socially Modifiable Contingencies in Mental Health" *Journal of Health and Social Behavior* 44:1–17.

Veroff, Joseph, Richard Kulka and Elizabeth Nourna. 1981. *Mental Health in America: Patterns of Health-Seeking from 1957–1976.* New York: Basic Books.

Wahl, O.F. 1995. *Media Madness: Public Images of Mental Illness*. New Brunswick, N. J.: Rutgers University Press.

Weinstein, Raymond. 1982. "The Mental Hospital from the Patient's Point of View." Pp. 121–46 in *Deviance and Mental Illness* edited by W. Gove. Beverly Hills, California: Sage Publications.

———. 1994. "Goffman's *Asylums* and the Total Institution Model of Mental Hospitalization." *Psychiatry* 57:348–67.

Whitt, Hugh P. and Richard L. Meile. 1985. "Alignment, Magnification and Snowballing: Processes in the Definition of Symptoms of Mental Illness." *Social Forces* 63:682–97.

Wilson, Mitchell, M.D. 1993. "DSM-III and the Transformation of American Psychiatry: A History." *American Journal of Psychiatry* 150:399–410.

Wright, Eric., William. Gonfrein, Timothy. Owens. 2000. "Deinstitutionalization, Social Rejection, and the Self-Esteem of Former Mental Patients." *Journal of Health and Social Behavior* 41:68–90.

Yarrow, Marion, Charlotte Schwartz, Harriet Murphy, and Leila Deasy. 1955. "The Psychological Meaning of Mental Illness in the Family." *Journal of Social Issues* 11:12–24.

Walter R. Gove is Professor of Sociology Emeritus at Vanderbilt University. At present he is living in a remote part of the canyonlands of southern Utah where he combines his sociological research with a variety of outdoor activities. He has published widely in the areas of mental health, gender, family, criminology, deviance, aging and biosociology.

This content downloaded from 134.121.47.100 on Mon, 23 Nov 2015 05:37:42 UTC
All use subject to JSTOR Terms and Conditions